EQUALITY IMPACT ASSESSMENT AND ANALYSIS

South Gloucestershire's Children and Young People's Mental Health Strategy, 2016-2021

SECTION 1 – INTRODUCTION

Mental health impacts on all aspects of life, including quality of life, emotional wellbeing, physical health and even length of life. Mental health of children and young people in particular, also affects a child's development including their cognitive abilities, their social skills as well as their emotional wellbeing.[1] In 2012, the Health and Social Care Act placed mental health on a par with physical health with the duty of Parity of Esteem, with an emphasis on both recognising the interface between physical and mental health *and* on valuing physical and mental health equally.

One in ten children and young people aged 5-16 years, suffers from a diagnosable mental health disorder[2] and more than half of all adults with mental health problems were diagnosed in childhood, with less than half treated appropriately at the time.[3]

Children and young people's mental health and wellbeing is a complex issue with many influencing factors including peer, parental, educational and societal influences.[4] The social and biological influences on a child's health and brain development begin even before conception and continue through pregnancy and the early years of life,[5] thus emphasising the importance of early intervention, not just in the early years and during childhood but also looking at the health and mental health of parents, supporting the need for a life-course approach to addressing mental health.

The economic case for investment is strong.[6] The total cost of mental health problems in England have been estimated at £105 billion, including the direct costs of services and indirect costs associated with lost productivity and reduced quality of life.[7] Mental ill health is the single largest cause of disability in the UK. Child mental disorders produce costs across the health, education and social care system as well as in the community, police, criminal justice and welfare systems. Investing early with effective intervention will save money in the NHS and wider society. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood.[8]

The Children and Young People's Mental Health Strategy is the first of its kind for South Gloucestershire and is complementary to the South Gloucestershire Adult Mental Health Strategy; it is informed by the Children and Young People's Mental Health Needs Assessment, which included consultation with children and young people and parents and carers. The strategy aims to provide a collective and collaborative vision to improve the mental health and emotional wellbeing

of children and young people in South Gloucestershire over the next five years in order to support the leadership and direction required to achieve this.

SECTION 2 –RESEARCH AND CONSULTATION

There are 80,860 0-24 year olds in South Gloucestershire and 64,200 0-19 year olds. Table 1 presents 2014 population estimates by age band and gender for South Gloucestershire.

Table 1: Population estimates 2014

	Males		Females		Total	
Age band (years)	**Number**	**% of age band**	**Number**	**% of age band**	**Number**	**% total SG pop**
0 – 4	8,323	51.3%	7,912	48.7%	16,235	6.0
5 – 9	8,229	50.5%	8,063	49.5%	16,292	6.0
10 – 14	7,429	50.7%	7,215	49.3%	14,644	5.4
15 – 19	8,883	52.2%	8,149	47.8%	17,032	6.3
20 – 24	8,942	53.7%	7,717	46.3%	16,659	6.1

Source: ONS 2015

Table 2 presents data on ethnicity for South Gloucestershire, by age band, taken from the 2011 census.

Table 2: Population by ethnic group and age band, 2011 census

	Ethnic group																	
Age band (years)	**English/Welsh/Scottish/ Northern Irish/British**	**Irish**	**Gypsy or Irish Traveller**	**Other White**	**White and Black Caribbean**	**White and Black African**	**White and Asian**	**Other Mixed**	**Indian**	**Pakistani**	**Bangladeshi**	**Chinese**	**Other Asian**	**African**	**Caribbean**	**Other Black**	**Arab**	**Any other ethnic group**
0-4	13,880	22	23	475	268	98	220	154	268	80	18	83	69	108	29	31	48	51
5-9	13,178	26	29	290	235	54	149	95	169	55	16	47	90	60	35	15	41	24
10-14	14,677	17	33	222	186	41	133	82	111	48	15	46	111	42	38	14	12	30
15-19	16,248	38	33	250	208	31	114	66	129	58	18	79	113	75	63	17	29	30
20-24	13,797	40	17	508	143	28	75	62	176	71	29	163	139	93	49	19	17	32

Source: ONS

Based on national estimates of prevalence, there are approximately 4,800 children aged 5-19 years who have a mental health disorder.

Prevalence estimates for mental health disorders in children aged 5-16 years have been estimated in a report by Green et al. (2004) and a breakdown by age and sex is presented in table 3.

Table 3: Estimated number of children with mental health disorders by age group and sex, South Gloucestershire 2014

Age band	Boys	Girls
5-10 years	870	440
11-16 years	1,075	815
Total (5-16 years)	1,945	1,250

Note: the numbers in the age groups 5-10 years and 11-16 years may not add up to those in the 5-16 year age group as the rates are different within each age group

Key protected characteristic groups are highlighted below with reference to mental health and national and/or local research and data.

Gender

Mental health problems affect both boys and girls, but some types of mental health problem are more common in boys and some are more common in girls. The estimated prevalence of mental health disorders is higher in South Gloucestershire amongst boys except for emotional disorders which is estimated to be higher for girls. National data estimates that for 16-19 year olds in South Gloucestershire, more females are diagnosed with neurotic disorders such as 'mixed anxiety and depressive disorder' than males. However, more males are estimated to have a diagnosis of 'generalised anxiety disorder' and 'obsessive compulsive disorders'.

In 2015, data on over 6,000 South Gloucestershire pupils aged 8-18 was collected via the Online Pupil Survey (OPS). More male respondents than female stated they are confident about the future; girls tend to be less confident than boys and it declines sharply in years 10 and 12 and generally boys feel safer outside than girls. Overall 11% of respondents stated they were unhappy, but this differed between girls and boys, particularly in the older years with, for example, 26% of girls in year 12 reporting they were unhappy compared to 12% of boys. One in three girls report being so worried they cannot sleep compared to 1 in 10 boys.

Age

We know that mental health and wellbeing of a child is impacted on from an early age, even before conception, therefore addressing mental health at all ages is vital, including those transitioning from child to adult (i.e. 18-25 year olds) as highlighted in the South Gloucestershire Mental Health Needs Assessment. Although mental health problems can affect children and young people at any age, national estimates do suggest children aged 11-16 years old are more likely than 5-10 year

olds to experience mental health problems, with 7.3% of 5-10 year olds estimated to have a mental health problem compared to 10.1% of 11-15 year olds.[9] Data on the mental health of children and young people aged 16 and over are from a different survey and so are not comparable but estimates suggest that for children and young people aged 16-24 years, 2.2% had experienced a depressive episode, 4.7% screened positive for posttraumatic stress disorder, 16.4% had experienced anxiety disorder, 0.2% had had a psychotic illness and 1.9% had a diagnosable personality disorder.[10]

The results of the Online Pupil Survey for South Gloucestershire (2015) showed that a lower proportion of pupils in the primary phase (years 4, 5 and 6) described themselves as unhappy (8%), compared to pupils in the secondary phase (years 8, 10 and 12; 16%).

Lesbian, gay, bisexual and transgender (LGBT)

There are certain groups of children and young people who, due to their individual circumstances and/or presentation, have an increased risk of developing emotional health and mental health problems and experiencing poor health outcomes. Lesbian, gay, bisexual or transgender children and young people have been identified as such a group. The reasons for this are complex and not yet fully understood, however mental health problems experienced by LGBT people have been linked to discrimination, bullying and homophobia, biphobia or transphobia.[11] For example, more than half (55%) of lesbian, gay and bisexual (LGB) people experience homophobic bullying in Britain's schools, whilst almost half (46%) of gay pupils who experience homophobic bullying have symptoms consistent with depression; 35% of gay young people who aren't bullied are also likely to be depressed compared to just 5% of young people generally[12]. It is estimated that 7% of the 16-24 year old population in the UK are LGB.[13]

Black, Asian and Minority Ethnic (BAME) groups

Another group of people who are at increased risk of developing mental health problems are people from some Black, Asian and Minority Ethnic (BAME) groups. Different ethnic groups have different rates and experiences of mental health problems, reflecting their cultural and socio-economic contexts and access to culturally appropriate treatments.[14] For example, evidence indicates that Pakistani and Bangladeshi groups are more likely to experience poor mental health.[15] The risk of mental health problems is estimated to be nearly twice as likely for Bangladeshi men than for white men[16], whilst a recent study of young people of Asian origin in the UK found that the suicide rate of 16-24 year old women was three times that of 16-24 year old women of white British origin.[17] Gypsy and Irish travellers are known to have significantly poorer health status (including mental health) than the general population, with particular issues regarding access to health services and high levels of loss and bereavement.[18] Current research on variation in mental health and ethnicity in the UK and elsewhere is limited and remains largely inconclusive.

However, it is well established that ethnicity, race and culture can influence mental health problems either as proxies for socio-economic or socio-cultural determinants (e.g. poverty or racism) or the way services are accessed and interventions are accepted.[19] In England, younger people from ethnic minorities were more likely to report experiencing harassment on the basis of skin colour, race or religion.[20]

Religion

Religion itself is not a risk factor for mental health problems, however, as with minority ethnic groups, it may be that religion acts as a proxy for socio-cultural determinants of mental health problems. An example is that children and young people could experience stigmatisation and bullying as result of their religion, but they could also experience these for a range of other reasons. In England, younger people from ethnic minorities were more likely to report experiencing harassment on the basis of skin colour, race or religion.[21] Another example of religion as a socio-cultural determinant of mental health is that t has been shown that religious minorities have significantly higher unemployment rates than those with no religion and as unemployment is a known risk factor for mental health problems, religious minorities may therefore be at higher risk.[22]

Disability

People with a physical disability or with special education needs and disability (SEND) are at increased risk of developing mental health problems. A 2012 report published by *The King's Fund* and *Centre for Mental Health* highlighted that individuals with physical health problems are at increased risk of poor mental health, particularly depression and anxiety,[23] whilst a 2007 UK population-based study of 1023 people with learning disabilities found that 54% had a mental health problem.[24]

In South Gloucestershire, the Online Pupil Survey (2015) found that pupils who identified as having special education needs or a disability were significantly less happy than mainstream pupils, both for those in primary school years (4,5 and 6) and secondary school years (8, 10 and 12).

In terms of need, routine data are collected on SEND, although this does not reflect the spectrum of disability and is only a proxy for severity. The proportion of children with a SEND in 2014 was 3.0%. The precise number of children with physical disabilities in South Gloucestershire is unknown, but figures based on national estimates are that 3.0-5.4% of children have disabilities, equating to between 1,607 and 2,893 children with some level of disability.[25]

Pregnancy and maternity

The social and biological influences on a child's health and brain development begin even before conception and continue through pregnancy and the early years of life,[26] thus emphasising the

importance of early intervention, not just in the early years and during childhood but also looking at the health and mental health of pregnant mothers and the early years of life. Specialist services and targeted interventions are important for ensuring good mental health of not only the mother but also the child.

There is a strong link between parental (particularly maternal) mental health and children's mental health.[27] One study[28], for example, found that maternal anxiety during pregnancy predicted behavioural and emotional problems for the child at age 4.[29] In terms of local need, it is estimated that there will be a 6% increase in births from 2013 to 2037 across maternal age groups.

Table 4: Overview of research and protected characteristic groups for children and young people's mental health

Protected characteristic group	**Summary of research**
Gender	• The estimated prevalence of mental health disorders overall is higher amongst boys, except for emotional disorders which are estimated to be higher for girls. • For 16-19 year olds, more males are estimated to be diagnosed with neurotic disorders such as 'generalised anxiety disorder' and 'obsessive compulsive disorders'. • For 16-19 year olds, more females are estimated to be diagnosed with neurotic disorders such as 'mixed anxiety and depressive disorder' than males.
Age	• Mental health can affect people of all ages. • 11-16 year olds are more likely than 5-10 year olds to experience mental health problems • For 16-24 year olds, 2.2% have experienced a depressive episode, 4.7% have screened positive for posttraumatic stress disorder, 16.4% have experienced anxiety disorder, 0.2% have had a psychotic illness and 1.9% have a diagnosable personality disorder
LGBT	• 55% of lesbian, gay and bisexual (LGB) people experience homophobic bullying in school. • 46% of gay pupils who experience homophobic bullying have symptoms consistent with depression. • 35% of gay young people who aren't bullied are also likely to be depressed compared to just 5% of young people generally.
BAME	• Different ethnic groups have different rates and experiences of mental health problems, reflecting their cultural and socio-economic contexts and access to culturally appropriate treatments, • e.g. the risk of mental health problems is estimated to be nearly twice as likely for Bangladeshi men than for white men [not children and young people specific].
Religion	• Religion may act as a proxy for socio-cultural determinants of mental health problems; • e.g. religious minorities have significantly higher unemployment rates than those with no religion and unemployment is associated with higher risk of mental illhealth.
Disability	• Individuals with physical health problems are at increased risk of poor mental health, particularly depression and anxiety.

	• One study found that 54% of people with learning disabilities had a mental health problem [not children and young people specific].
Pregnancy and maternity	• There is a strong link between parental (particularly maternal) mental health and children's mental health; • e.g. one study found that maternal anxiety during pregnancy predicted behavioural and emotional problems for the child at age 4.

Consultation results[30]

The consultation was open between 11 October and 6 December 2016. A survey was made available online and in paper at libraries and one stop shops, and consultees were also invited to respond by email, telephone or post. The consultation was publicised through a number of channels, including: community and voluntary services and organisation (e.g. CVS, Southern Brooks Partnership, Citizens Advice Bureau, Barnardo's), health and disability groups (e.g. Health Watch, Care Forum, Parent and Carer Forum, South Gloucestershire CCG, North Bristol NHS Trust) and ethnicity groups and organisations (e.g. South Gloucestershire Asian Project, Race Equality Network), South Gloucestershire Public Health and Wellbeing colleagues.

On South Gloucestershire Council's consultation website, there were 41 downloads of the Initial Equalities Impact Assessment, 51 downloads of the summary document and 33 downloads of the paper survey, demonstrating some engagement by the public. However, the consultation receive a low response rate; 12 online surveys were completed and 2 emails were received.

Only 8 out of 12 of respondents completed the equalities section, thus it was not possible to undertake a detailed equalities analysis of consultees. Overall, 6 out of 8 were aged 25-44 years and 2 out of 8 were aged 45 to 64 years; the male to female split was 50:50. All respondents identified themselves as non-disabled and 7 out of 8 respondents were white British and 1 of the 8 was non-white British.

Although this suggests a low engagement with particular groups of people, it is worth highlighting that extensive consultation with children and young people, parents and carers and professionals took place, both in undertaking the needs assessment and in writing the strategy. The low response rate therefore may suggest that people felt that had been given sufficient opportunity to influence the strategy in its development and so did not feel necessary to comment further.

Overall, the majority of respondents (9 out of 12) agreed that the strategy captures the main issues relating to children and young people's mental health and emotional wellbeing in South Gloucestershire and only 1 respondent disagreed. This individual indicated they were responding as a health or social care professional. All respondents agreed with the themes that the strategic aims are based on.

Few comments were made identifying inequalities in terms of groups likely to be disproportionately affected by the strategy or groups who were missing altogether. A summary of equalities related feedback is provided below:

- No mention of eating disorders;
- Lack of reference to those in child poverty;

- Children with autism not addressed;
- Young people in supported housing and accessing floating support missing;
- Children in refuge houses (domestic abuse) missing;
- Young carers not taken into account as much as could be.

SECTION 3 - IDENTIFICATION AND ANALYSIS OF EQUALITIES ISSUES AND IMPACTS

The following table contains the key points from research and consultation:

Table 5: Overview of research and consultation key points relating to inequalities for children and young people's mental health

Protected characteristic group	Summary of research
Gender	• The estimated prevalence of mental health disorders overall is higher amongst boys, except for emotional disorders which are estimated to be higher for girls. • For 16-19 year olds, more males are estimated to be diagnosed with neurotic disorders such as 'generalised anxiety disorder' and 'obsessive compulsive disorders'. • For 16-19 year olds, more females are estimated to be diagnosed with neurotic disorders such as 'mixed anxiety and depressive disorder' than males.
Age	• Mental health can affect people of all ages. • 11-16 year olds are more likely than 5-10 year olds to experience mental health problems • For 16-24 year olds, 2.2% have experienced a depressive episode, 4.7% have screened positive for posttraumatic stress disorder, 16.4% have experienced anxiety disorder, 0.2% have had a psychotic illness and 1.9% have a diagnosable personality disorder
LGBT	• 55% of lesbian, gay and bisexual (LGB) people experience homophobic bullying in school. • 46% of gay pupils who experience homophobic bullying have symptoms consistent with depression. • 35% of gay young people who aren't bullied are also likely to be depressed compared to just 5% of young people generally.
BAME	• Different ethnic groups have different rates and experiences of mental health problems, reflecting their cultural and socio-economic contexts and access to culturally appropriate treatments, • e.g. the risk of mental health problems is estimated to be nearly twice as likely for Bangladeshi men than for white men [not children and young people specific].
Religion	• Religion may act as a proxy for socio-cultural determinants of mental health problems; • e.g. religious minorities have significantly higher unemployment rates than those with no religion and unemployment is associated with higher risk of mental ill health.
Disability	• Individuals with physical health problems are at increased risk of poor mental health, particularly depression and anxiety. • One study found that 54% of people with learning disabilities had a mental health problem [not children and young people specific].
Pregnancy and maternity	• There is a strong link between parental (particularly maternal) mental health and children's mental health; • e.g. one study found that maternal anxiety during pregnancy predicted behavioural and emotional problems for the child at age 4.
Other	• No mention of eating disorders in strategy • Lack of reference to those in child poverty; • Children with autism not addressed; • Young people in supported housing and accessing floating support missing;

	• Children in refuge houses (domestic abuse) missing; • Young carers not taken into account as much as could be.

Our response

South Gloucestershire's Children and Young People's Mental Health Strategy aims to enable *all* children and young people in the area to enjoy good mental health and emotional wellbeing. It is therefore unlikely to negatively impact on any particular group.

However, opportunities have been identified to improve the mental health of young people whilst taking into account their protected characteristic status. As such, the strategy identifies seven key priority areas to be addressed:

1. Develop an integrated whole system approach: this area will ensure there is a coordinated, collaborative, joined up approach which addresses the mental health of *all* children and young people in South Gloucestershire, thus impacting on all protected groups;
2. Promote resilience, prevention and early intervention: this area will consider the whole family context and will include a range of actions to promote positive mental wellbeing, prevent mental ill health and ensure early identification and intervention. Much of the focus will be on increasing the emotional resilience of all children and young people and many interventions will be delivered in school settings and so will impact on all protected groups;
3. Improve access to effective support: this area will focus on ensuring there is a range of person-centred and flexible mental health services which are available and accessible for all, including those in the protected characteristic groups;
4. Care for the most vulnerable: this area is the most important for equalities because it focuses on vulnerable groups, including BAME groups, LGBT, those with physical disabilities and those with SEND. It will understand and address the risks and specific needs of these groups.
5. Workforce development for non-specialists: this area will focus on training and support for those working with children and young people; it provides clear opportunities to provide universal promotion and prevention services and provide early identification and signposting to services, which will impact on all protected groups.
6. Communication: this area will be responsible for provision of information to children and young people and their families through various means and therefore will impact on all protected groups;
7. Perinatal, infant and maternal mental health: this area will be responsible for promoting the best start for all children through work with mothers through pregnancy and the early years of life and therefore will impact on all priority groups.

These seven areas will focus on prevention (i.e. universal services for all) through to early intervention and treatment and will cover children and young people from conception through early years and school years to those in the transition years.

As a result of the information in Sections 1 and 2 and the details on each of the key priority areas above, the likely impact of the strategy in relation to protected characteristic groups are outlined below.

Gender

Mental health problems affect both boys and girls; as a result there is not a sole focus on either girls or boys in the strategy. Actions will impact on all children and young people, regardless of gender and will not have a greater impact on one group compared to another.

It is worth noting that some types of mental health problem are more common in boys and some are more common in girls; the estimated prevalence of mental health disorders in South Gloucestershire, for example, is higher amongst boys except for emotional disorders which is estimated to be higher for girls. By focusing on prevention, building emotional resilience of children and young people, considering early intervention, improving service provision and adopting a whole family approach, as well as focusing on all age groups, this strategy aims to improve the mental health of both boys and girls for all types of mental health problem. Key priority areas 1, 2, 3, 5 and 6 in particular will address this area.

Age

Mental health can affect children and young people at any age. The evidence highlights that it is important to consider the life-course approach to mental health as experiences in conception, pregnancy and early years can impact on mental health and wellbeing later in life. Therefore, this strategy considers all ages, from conception through to the transition years. Examples include:

- a working group to consider actions specifically for perinatal, infant and maternal mental health;
- inclusion of those in transition years (18-25 years) as a vulnerable group, which will be addressed under key priority area 4 ‘care for the most vulnerable’; the strategy also acknowledges that services should be flexible based on needs of the individual not their age, a feature which is also adopted by the Adult Mental health strategy.
- workforce development for people working with all ages of pupils, e.g. primary and secondary school;
- increasing emotional resilience of school aged pupils;
- addressing care for those who require access to mental health services, at any age.

It is likely that this strategy will have a greater impact on pupils of secondary school age will be than primary age pupils due to the high level of 'risk' and 'need' associated with those aged 11 and over (e.g. interventions delivered in secondary school, training of teachers and availability of therapeutic interventions (talking therapies) to those aged 11-16); national estimates support this approach as children aged 11-16 years are more likely to experience mental health problems than those aged 5-10 years. However, work will also be done to ensure the mental health of younger children are also addressed (e.g. working with primary schools) as well as older pupils and those in the transition years. Key priority areas 1, 2, 3, 5, 6 and 7 in particular will address this area.

Lesbian, gay, bisexual or transgender (LGBT)

This group is identified as a vulnerable group within the strategy, which are addressed by key area 4: *care for the most vulnerable*. Children and young people who are LGBT will have many opportunities to receive and benefit from interventions to improve their mental health through the actions identified in key area 4. For example, interventions delivered in schools to build emotional resilience or campaigns to address stigma and bullying across a range of risk factors (e.g. appearance, sexuality, disability, race). Key areas 1, 2, 3, 4, 5 and 6 in particular will address this area.

Black, Asian and Minority Ethnic (BAME) groups

As above, this group (including gypsy and travellers) is identified as a vulnerable group within the strategy, which are addressed by key area 4: *care for the most vulnerable*. Children and young people from BAME groups will have many opportunities to receive and benefit from interventions to improve their mental health through the actions identified in key area 4. For example, interventions delivered in schools to build emotional resilience or campaigns to address stigma and bullying across a range of risk factors (e.g. appearance, sexuality, disability, race). Key areas 1, 2, 3, 4, 5 and 6 in particular will address this area.

Religion

There is limited evidence investigating the mental health of children and young people with regards to religion. However, it is likely that this group will be impacted as part of wider actions, such as campaigns to address stigma and bullying. Children from all religions will have opportunities to receive and benefit from interventions to improve their mental health and emotional wellbeing. Key areas 1, 2, 3, 4, 5 and 6 in particular will address this area.

Disability

As previously, children and young people with disabilities are identified as a vulnerable group within the strategy, which are addressed by key area 4: *care for the most vulnerable*. Children and

young people with disabilities will have many opportunities to receive and benefit from interventions to improve their mental health through the actions identified in key area 4. For example, interventions delivered in schools to build emotional resilience or campaigns to address stigma and bullying across a range of risk factors (e.g. appearance, sexuality, disability, race). Key areas 1, 2, 3, 4, 5 and 6 in particular will address this area.

Pregnancy and maternity

It is widely acknowledged that pregnant women are at risk of mental health problems. In addition, it is accepted that influences on health begin before conception and continue during pregnancy and early years of life.

A local perinatal depression (PND) strategy group has recently been formed for South Gloucestershire; this group will be responsible for key priority area 7 of the strategy: *perinatal, infant and maternal mental health.* This group consists of representation from the voluntary sector (including service user voice), Avon & Wiltshire Mental Health NHS Trust, North Bristol NHS Trust, South Gloucestershire Clinical Commissioning Group and South Gloucestershire Council and will be responsible for provision of specialist services and targeted interventions to improve the health and mental health of women in pregnancy, mothers and children in their early years of life. Key areas 1, 6 and 7 in particular will address this area.

Other

Eating disorders

It is acknowledged that eating disorders are a serious mental health problem and that there is no explicit mention in the strategy. It has therefore been added to the list of vulnerable groups.

Local support for CYP suffering with eating disorders will be addressed through the key priority area 3 *'Improving access to effective support'.* Eating disorders is a current national focus of CAMHS and funding has been made available to address the issue.

It is anticipated that this area will also be addressed through the prevention and early intervention work which will happen. We are participating in a pilot project with UWE and two schools on early intervention and prevention for eating disorders. A national training programme has just been announced to support professionals in schools working with young people affected by eating issues. South Gloucestershire will participate in this programme.

Child poverty

The strategy has been modified to include more explicit reference to the wider structural, cultural and environmental drivers, risk factors and protective factors, which impact on the mental health of CYP. Explicit reference is made to child poverty.

Autism

It is acknowledged that CYP with autism are a group that a particularly vulnerable in terms of mental health and emotional wellbeing. In South Gloucestershire there is clear area of need with regards to CYP with autism.

Following stakeholder discussions, we used the term 'social and communication difficulties', which includes those on the autistic spectrum. CYP with social and communication difficulties are identified as a vulnerable group within the strategy and therefore will be addressed by the working group focused on *'Care for the most vulnerable'.*

A working group has been established to develop and take forward actions for this key priority area.

In addition to this, the strategy also recognises the work of and links with other areas of work within the council and reference the Autism Strategy Group in particular, who are undertaking specific work in this area.

Examples of other work which is happening or proposed in this area is the provision of additional funding to help with tackling the waiting list and improve the time to diagnosis for CYP with autism, additional funding for parenting support and the planned development of an autism needs assessment.

Young people in supported housing and accessing floating support

This has been added to the list of vulnerable groups included in the strategy and therefore comes under key priority area 4 *'Care for the most vulnerable'.*

Children in refuge houses (domestic abuse)

This has been added to the list of vulnerable groups included in the strategy and therefore comes under key priority area 4 *'Care for the most vulnerable'.*

Young carers

Young carers are identified within the strategy both as a stakeholder group and as a vulnerable group. We also held a specific meeting with the Young Carers Participation group as part of the needs assessment process.

One of the seven key priority areas for achieving the strategy vision is *'Care for the most vulnerable'.* A working group has been established to develop and take forward actions for this key priority area.

The strategy also recognises the work of and links with other areas of work within the council. In particular, South Gloucestershire Council has recently consulted on a Carers Strategy, which is currently under development and is likely to impact on young carers.

SECTION 4 - EqIAA OUTCOME

Outcome	Response	Reason(s) and Justification
Outcome 1: No major change required.	☐	
Outcome 2: Adjustments to remove barriers or to better promote equality have been identified.	☒	The consultation highlighted some key groups which needed to be addressed by the strategy to better promote equality for all children and young people in South Gloucestershire.
Outcome 3: Continue despite having identified potential for adverse impact or missed opportunities to promote equality.	☐	
Outcome 4: Stop and rethink.	☐	

SECTION 5 - ACTIONS TO BE TAKEN AS A RESULT OF THIS EqIAA

As a result of this Equality Impact Assessment and Analysis for South Gloucestershire's Children and Young People's Mental Health and Emotional Wellbeing Strategy, the following actions have been or will be taken:

- Relevant changes/additions made to the strategy (as discussed in section 3) to ensure all groups will be positively impacted on through implementation of the strategy;
- Ensure that a wide range of service user feedback continues to be used to identify any emerging issues on an ongoing basis;
- Ongoing monitoring to disaggregate according to protected characteristic group as appropriate and/or possible (e.g. age, gender).

SECTION 6 - EVIDENCE INFORMING THIS EqIAA

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